EXHIBIT 1
DATE 3/11/13
SB 172

Montana Dental Association
P.O. Box 1154, Helena, Montana 59624

(406) 443-2061
Toll-free in Montana
(800) 257-4988
fax: (406) 443-1546
E-mail: info@montanadental.org
www.mtdental.com

Statement: Senate Bill 172
Montana Dental Association
House Committee on Human Services
March 11, 2013

The Montana Dental Association supports SB 172, which will prohibit insurers from dictating the fees a dentist can charge for dental services that are not covered in a dental benefit plan.

Dental benefit plans define which specific services the insurer will cover for the insured patient. A provider contract between the insurer and a dentist governs the fee that the dentist is allowed to charge the patient for those covered services

Some provider contracts go further, however, and allow the insurer to dictate the fee the dentist may charge for services that are not covered in the patient's dental benefit plan. The dentist must write off the cost of those services or shift the cost to other patients. Because dentists have no negotiating power in determining these "take it or leave it" contracts, they are bound by this detrimental provision.

SB 172 will prohibit provider contracts from including unfair provisions that allow the insurer to dictate fees for non-covered services.

SB 172 is based on model legislation approved by the National Council of Insurance Legislators in 2010. Similar legislation has been approved in 29 other states, including North and South Dakota, Wyoming and Idaho. SB 172 was unanimously passed by the Senate.

Please approve SB 172 with a "do pass" recommendation.

Why Montana needs SB 172 to prohibit insurers from dictating prices on non-covered dental benefits.

The Issue

1. **Market power abuse:** Some insurance companies can use their market power to dictate prices for dental services that insurance companies don't cover as part of a patient's dental benefit plan. This is a very substantial change in how insurance contracts with dental providers have been structured for years.

2. **Dentists have limited recourse:** Because of antitrust restrictions, dentists cannot band together to demand fair treatment and resist market power by insurance companies. As small businesses, the only way dentists can seek relief from non-negotiable "take it or leave it" contracts is through legislation.

3. **Insurers gain, consumers lose by cost shifting:** Insurers try to dictate prices for non-covered services to make their plans appear more attractive in the market place. However, the artificial pricing set by insurers doesn't save any money; it will instead result in a cost shifting from those covered under the particular insurance plan to everyone else – especially those who have no dental insurance and who may be least able to pay.

4. **Examples:** Because of this practice, Montana dentists who are participating providers in some insurance networks cannot charge their normal fee for some services, such as composite (tooth-colored) fillings, sealants for adult patients, veneers, implant treatment and some x-ray procedures, even though these are non-covered benefits.

5. **Impact on dental practices**: Dental offices are surgical suites, and hence have high overhead costs - upwards of 65%. Dictating fees on non-covered services can have a troubling impact on the viability of some dental practices—particularly those in low-income and underserved areas.

6. **SB 172** was drafted based on model legislation approved by the National Council of Insurance Legislators in 2010. The same bill has been passed in 29 other states, including North Dakota, South Dakota, Wyoming and Idaho. It passed the Montana Senate unanimously.

Montana Dental Association
For further information, contact:

David Hemion, MDA Executive Director. (800) 257- 4988, dave@montanadental.org

Jim Ahrens, MDA lobbyist, (406) 439 -1585, ahrens@3riversdbs.net

Questions about SB 172

1. Why should the Legislature interfere in contracting between businesses?

   All SB 172 does is provide protection from unfair business practices. This is about leveling the playing field between dental practices, which are small businesses, and large insurance companies. The state routinely sets limits on insurance business practices to ensure a fair marketplace, such as prompt pay laws.

2. Can't a dentist just refuse to join a PPO?

   Unlike hospitals and large group medical practices, dentists have little or no negotiating power in agreements with major insurers. These dental provider contracts are "contracts of adhesion"; meaning one side has all the bargaining power and the other none, so there is no flexibility in terms. Consequently, if the employer of a large group of patients switches plans, a dentist may have no choice but to accept the unfavorable terms of the new PPO or lose many of the practice's long-time patients.

   Also, like all large businesses, the insurance industry is not static and ownerships may change, as we are witnessing here in Montana. The upcoming insurance exchange will make dental benefits more subject to market pressures that can result in patients changing insurers to those who have unfair PPO agreements for dentists.

3. How will patients be affected?

   Dictating fees on non-covered services forces dentists to shift the cost saved by an insured patient onto a patient who does not have a dental benefit plan. Their treatment becomes more expensive because the insurer unfairly and artificially lowers the cost to the insured patient for services not included in their plan.

4. How many Montana dentists does this affect?

   There are hundreds of Montana dentists who are participating provider for dental benefit plans.

5. What's a non-covered service?

   A dental plan includes procedures and treatment that are covered as benefits. Those procedures that are not included in the list of benefits are not covered, such as certain types of radiographs, veneers, sealants for adults, some materials used in restorations, and some implant procedures.

6. Are insurers opposed to this bill?

   MDA has worked to discus the bill with major insurers. Several have indicted they are not opposed, but MDA is also concerned about insurers who may enter the Montana market or those who may later alter the terms of their PPO agreements

NCOIL
National Conference of Insurance Legislators
...for the states

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS (NCOIL)
Model Act Banning Fee Schedules for Uncovered Dental Services

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Adopted by the NCOIL Executive Committee on November 21, 2010, and by the NCOIL Health, Long-Term Care & Retirement Issues Committee on November 20, 2010.

Section I. Summary
This Act would prohibit a dental insurance plan from requiring a dentist who provides services to its subscribers to accept a fee set by the plan for any services except covered services.

Section II. Definitions
A. "Covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

B. "Dental plan" shall include any policy of insurance which is issued by a health care service contractor which provides for coverage of dental services not in connection with a medical plan.

Section III. Contracts With Providers For Dental Services
A. No contract of any health care service contractor that covers any dental services, and no contract or participating provider agreement with a dentist may require, directly or indirectly, that a dentist who is a participating provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the health care service contractor unless the dental services are covered services.

Drafting Note: Concerns exist that dental plans may react by adopting a strategy of covering all services at a nominal or de minimus fee. Such a strategy by dental benefit plans, to adopt or impose a deductible, co-payment, co-insurances or any other requirement in such a way as to provide de minimus reimbursement and avoid the impact of this model bill is contrary to the spirit and intent of this model legislation. States should consider setting a threshold of what payment would constitute; for example, "50 percent of the dentists' prevailing fee, administered consistently with policies traditionally governing covered services."

B. A health care service contractor or other person providing third party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

Section IV. Penalties
Penalties provided for in *[Insert Applicable State Statute Concerning Dental Plan Contracts]* shall apply to any violation of this Act.

Section V. Severability
If any section, clause, or provision of this chapter shall be held either unconstitutional or ineffective in whole or in part to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be termed invalid or ineffective.

Section VI. Effective Date
This Act shall take effect immediately.

2013 Montana Legislature

Additional Bill Links PDF (with line numbers)

SENATE BILL NO. 172

INTRODUCED BY E. WALKER

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING A DENTAL INSURANCE PLAN FROM REQUIRING A PARTICIPATING DENTIST TO ACCEPT A FEE SET BY THE PLAN FOR ANY SERVICES EXCEPT COVERED SERVICES; PROHIBITING NETWORKS FROM SETTING DENTAL FEES OTHER THAN FOR COVERED SERVICES; PROVIDING A PENALTY; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Provider agreement limited to covered services -- dental network constraints -- penalty -- definitions.** (1) A provider agreement entered into or renewed on or after July 1, 2013, between dentists licensed under Title 37, chapter 4, and an issuer that offers an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services may not:

(a) require the dentist to provide dental services to an individual covered under the excepted benefits plan or health benefit plan at a fee set by or subject to the approval of the issuer unless the dental services are covered services; or

(b) prohibit the dentist from offering or providing to an individual covered under the excepted benefits plan or health benefit plan any dental services that are not covered services. The fee for the noncovered services may be determined only under terms or conditions set by the dentist or negotiated by the dentist with the individual covered under the excepted benefits plan or health benefit plan.

(c) provide minimal coverage for covered services under the provider agreement for the sole purpose of avoiding the requirements of this section.

(2) A business entity that owns a network of health care providers and markets access to that network may not circumvent the terms of this section by making available to an issuer of an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services any dentists

in that network if the business entity sets dental services fees in its network for any services except covered services.

(3) An issuer of an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services is subject to a fine as provided in 33-1-317 for a violation of this section.

(4) For the purposes of this section, the following definitions apply:

(a) "Covered services" means dental care services provided under a plan for limited-scope dental benefits or a health benefit plan for which a payment is available subject to the application of contractual terms, including but not limited to annual or lifetime maximums, deductibles, copayments, coinsurance, waiting periods, frequency limitations, or alternative benefit reimbursement.

(b) "Issuer" includes an insurer, a health service corporation, or a third-party administrator that offers or administers an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services.

NEW SECTION. **Section 2. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [section 1].

NEW SECTION. **Section 3. Effective date.** [This act] is effective July 1, 2013.

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